Title II and/or Title XVI Disablity Claim

REQUEST FOR MEDICAL COMMENTS

1. ☐ OAO ☐ Civil Actions
☐ Request for Review ☐ New Court Case
☐ Comprehensive Review ☐ Court Remand

2. CLAIMANT (OR APPLICANT IF SSI CLAIM)

3. SSN

4. ANALYST AND DATE

5. REVIEWER AND DATE

6. DOB

7. ☐ Cessation
☐ Initial Entitlement ☐ Prior Referral
☐ New Referral ☐ Title XVI
☐ Title II

8. Alleged onset date (where applicable)

9. Date E/R Last Met (where applicable)

10. Period At Issue

11. Evaluation Needed on Body System(s) (Circle)

SKIN	EENT	MS	PSYCH	ENDO	CV
GU	MALIG	RESP	GI	N	HEMIC & LYMPH

12. ☐ Request for medical comments where a consultative examination may not be needed. Please see reverse side

13. ☐ We are proposing a recommendation to the Appeals Council that additional medical evidence be obtained. It is believed that (a single consultative examination with special tests or studies) (multiple examination) (is) (are) needed concerning the body system(s) indicated above. If you agree please enclose the modified "M" attachment showing the special tests or studies needed, or check boxes below if multiple examinations are needed. If multiple are recommended, please delete any duplicate tests or studies on the "M" attachments. Under "Pertinent Factors" on reverse side, we have included a statement of need for CE(s) with reference to pertinent exhibits.

14.

☐ M-1	☐ M-4	☐ M-6	☐ M-9	☐ M-12
☐ M-2	☐ M-5	☐ M-7	☐ M-10	☐ M-13
☐ M-3	☐ M-5A	☐ M-8	☐ M-11	☐ Other (Attached Paragraphs)

15. Also, please indicate below if the claimant should bring the following to the exam:

☐ Glasses or Contact Lenses

☐ Artificial limb or other prosthetic device

☐ Sample(s) of currently prescribed medicine

☐ Back Brace ☐ Hearing Aid

☐ Other (Explain) _____

16. Any additional remarks: _____

_____ Medical Staff

_____ Date

(THIS SIDE TO BE COMPLETED BY ANALYST WHERE APPROPRIATE)

17. MEDICAL TESTIMONY AT HEARING:

☐ None

☐ Medical Advisor ☐ See notes on left side of AF. ☐ See p.__ of (transcript) (hearing decision)

☐ Other (Claimant's physician, CE) ☐ See notes on left side of AF. ☐ See p.__ of (transcript) (hearing decision)

18. PERTINENT FACTORS (E.G.: MEDICAL HISTORY, DAILY ACTIVITIES, TESTIMONY, ETC.)

19. MEDICAL QUESTION OR PROBLEM:

FORM HA-542.1